STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155653	A. BUILDING _____ B. WING _____	C 07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE COUNTY NURSING AND REHABILITATION CENTER	**5025 MCCOOK AVE EAST CHICAGO, IN 46312**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaint IN00174936.

This visit was in conjunction with a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 5/1/2015. This visit included the PSR to the Investigation of Complaint IN00170228.

This visit was in conjunction with a PSR to the Investigation of Complaint IN00173777 completed on 5/26/2015.

Complaint IN00174936 - Substantiated. No deficiencies related to the allegations are cited.

Survey dates: July 1 and 2, 2015

Facility number: 000108
Provider number: 155653
Aim number: 100267410

Census bed type:
SNF/NF: 62
Total: 62

Census payor type:
Medicare: 4
Medicaid: 50
Other: 8
Total: 62

Sample: 3

Lake County Nursing and Rehab was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	Continued From page 1 Investigation of Complaint IN00174936.	F 000		